UTAH MEDICAID REFORM BILL – S.B. 180
DISCUSSION OF 1115 WAIVER – MEDICAID REFORM PRINCIPLES
PROVIDER FOCUS MEETING – INTEGRATING THE PHARMACY BENEFIT INTO THE ACO, OUT-OF-NETWORK PAYMENTS
APRIL 6, 2011 – CANNON HEALTH BUILDING ROOM 125
8:30-10:00 A.M.

Attendees: Jim Murray, Jesse Liddell, Todd Wood, Sean Dunroe, Stan Smith, Amy Bingham, Mike Hales, Gordon Crabtree, Michael Kelly, Barb Viskochil, Russ Elbel, Byron Okutsu, Paul Muench, Alan Pruhs, Allan Ainsworth, Sheila Walsh-Mc-Donald, Rod Betit, Mark Andrews, Cathy Dupont, Kim Wirthlin, Donna Gibbons, Aaron Eliason, Emma Chacon, Tim Morley, John Curless, Gail Rapp, E. Blake Anderson, Lincoln Nehring, Michelle McOmber, Gayle Coombs

Michael called the meeting to order at 8:30 a.m. He said there were two things we were going to discuss today.

1. The incorporation of the pharmacy benefit into the Accountable Care Organization (ACO) contract.

2. The limits on out-of-network payments.

Michael then had everyone introduce themselves.

Michael then began with some background and explained some of the changes that were made by the Affordable Care Act (ACA). He said right now the pharmacy benefit is a carved out service from our current Managed Care Contract. One of the ACA changes is that states can now claim pharmacy rebates on pharmacy claims that are dispensed through a Managed Care contract or through a Managed Care Organization. The state manages its drug benefit with two different groups – the Drug Utilization Review Board (DUR) and the Pharmacy and Therapeutics Committee (P&T).

Michael explained the Preferred Drug List (PDL). The PDL has been saving the state approximately $6,000,000 in general funds and close to $20,000,000 in state and federal funds. Michael said the current PDL has preclusion on allowing Psychotropic or Anti-Psychotic medications from being included on the PDL. It also has preclusion on Immunosuppressant medications. Therefore, these are drug classes that the Department of Health is not able to contemplate putting on the PDL. Michael said we also look at the way mental health services are delivered in the state and we have the capitated model in place for most of the state. We have Wasatch and San Juan Counties that are done on a fee-for-service basis, but other than that, the rest of the state is covered with a Mental Health Center having exclusive rights to deliver the mental health care for all the Medicaid clients in their area. Michael said the Mental Health Centers receive capitated premiums for the services they provide in terms of how they deliver care. Michael said the Mental Health Centers do not have any financial exposure or liability in regard to what drugs they prescribe. The pharmacy benefit is carved out of their scope of responsibility.

Michael said he feels we need to look at putting the pharmacy benefit into contracts with the ACOs because we would still be able to get the rebates. The prescribers would then have more financial incentive if they are in association with the ACOs and they are cost conscious in their prescribing habits. The question was asked as to whether it should be all of the drugs on the Medicaid program. Would we want to put the entire range of drugs into this ACO model? Should mental health drugs still be a carved out pharmacy benefit?

Barbara Viskochil mentioned some issues that NAMI had with moving some of the drugs to the PDL. Michael said nothing has been changed yet in regard to putting drugs on the PDL. Michael said the question here is the interpretation of the statute. Would we need statutory changes if the Managed Care Organizations take on the drugs in the mandatory drug list? Should the mental health drug classes be put on this list of what the ACOs would be responsible for? What would the ACOs be willing to take on as a risk in adding these drugs?

Molina's position is that they would really have to be careful about doing this. Paul Muench said being responsible for doing this could put a lot of pressure on being sure you have control over where the risk lies. Paul said it does make sense for the ACOs to have this control, but you would have to make sure of some other issues, also. Are there other changes that would have to be made to the statute in regard to this? Paul said he feels there would be better savings by bringing better vision to their members of what is out there for them to use. If Molina could see the data, it would help them with their client's health care needs.

Michael said if we do get some resolution on the mental health drugs and can put them on the PDL, would there be potential savings and so new ACOs would be willing to take this on? Paul said he thinks it would help, but we still would not be controlling the prescriber and we could not predict what the savings would be. Michael asked if the ACOs would be willing to take on this risk. He said we would be looking for feedback on this.

Lincoln Nehring had a question on whether the ACOs would want the patients if they could not control the mental health issues and their care. Michael said that population would not be carved out. We are strictly talking about the benefits they would have. It was asked if the carve out would just be in regard to specific providers. Michael said it would be a carve out of a specific drug class.

It was mentioned that a lot of Community Health Centers are now integrating mental health care along with regular health care. There were a lot of comments in regard to this. It was mentioned that this flexibility should be provided, but there would need to be some changes.

Michael said we are not talking about formularies but the PDL and what drugs are included with that. Michael explained the difference between a formulary and a PDL. It was mentioned that the Feds also require the PDL. The DUR would have some role with these groups.

Michael asked if Select Health or the University Health Care felt any different in regard to this. They said they have a lot of similar thoughts along the line that Paul was mentioning. It was mentioned that the DUR is a big issue with Select Health and with the University Health Care. Whether they would want to really carve out mental health drugs was asked and it was said that it would depend on how it was carved out. They said they would need the statutory requirements. It was mentioned that the costs could go way up if some of the patients did not have access to the mental health drugs they need. Checking with other states to get data on this and how that could help was mentioned. It was mentioned that there are some states that have done this and have shown a considerable savings. Paul said the issue along with this is the quality of the member and the outcome. Exceptions would have to be made to the chronically medically ill. Whether there are diagnoses that can determine whether someone is chronically medically ill was mentioned. Michael said the implementation date would be July 1, 2012, if CMS does approve this.

The ACOs would rather use their own plan for this rather than the PDL. Would they still be responsible to the PDL and DUR was mentioned. Michael said we would have to look into this. He said we would try and give the ACOs as much flexibility as we could on this but we would still need to know what is going on and be sure

everything is being followed. CMS usually comes up with terms and conditions when they sign the waiver. Michael said we would then bring that back to the ACOs when we explained the limitations.

Gordon Crabtree had some questions about what the federal statute would allow. Michael explained how each state would have to look at what the DUR would have to do in regard to coordinating with the ACO's, and there would be no formulary. The OBRA Law of 1990 was mentioned. In general, any pharmaceutical product on the market has to be included on the PDL.

Lincoln had some comments. Paul said the theory Lincoln is talking about makes sense, but he does not know how willing the providers would be to go along with this. It was mentioned that the providers need to be aware of the cost of the drugs that they are recommending to their patients.

Michael said one of the next steps here for us is to gather all the pharmacy information over the last few years for people in the different health plans. Michael said maybe we can come up with a plan and have all the Managed Care organizations look at this so they can decide what area they can manage on this. Needing a transition plan to go from the way the drugs are controlled now into having the Managed Care organizations control them was mentioned. Michael agreed that this would be needed.

Russ asked Michael to clarify something on this. Michael said we would also be going back over the past few years to look at what the pharmacy costs had been. We would probably have to break out the behavioral health drugs from this when we do it.

There would be no preclusion to using step therapy was mentioned by Paul, and Michael said that was right. Michael said that anti-psychotic and psychotropic were mentioned. Michael said that anti-psychotics are pretty well defined but the psychotropics are not. Michael said this could probably use some better defining in regard to these categories of drugs. Michael said he feels this is something we need to get clarified before we get into the next Legislative session.

Michael then discussed the rebates piece. He said the good change in the ACA allows that these drugs that are dispensed in ACOs are able to get a rebate, but the rebates are given to the state. The Department of Health would need the information from the providers in order to get the rebate. Michael said currently the state has a 15.1% minimum rebate from the manufacturers and the state has shared that with the federal government. It has now been increased to 23.1%, and the federal government takes back the extra 8% that was given. Michael said he thinks we will have to give the federal government about $6,000,000 a year back on the rebates. Michael said this is a budget hit that impacts the Medicaid Program.

Michael said he would like to give the health plans their pharmacy claims data so they can look and see what potential savings there might be. They could also look at the aggregate pool of what their savings are. Michael said they will also provide them with the rate reductions that will go into effect July 1, 2012. The 340B drugs are exempt from the rebates.

A question was asked in regard to what information will be shared on the rebate issue. Michael said one thing would be an operational issue after the contract is in place. The ACOs would have to let the Department of Health know what prescriptions they have given so we could get the rebates. Michael said since the Department of Health has all the information right now, he wants to be sure that the ACOs will have all this information. Michael said whether pharmacy information can be shared across different areas will have to be looked at to make sure it is not going against HIPPA. This is the same with the rebate information that the state would be able to share with the ACOs.

Gail Rapp said the health plans have been receiving the pharmacy claims data on their clients from the Department of Health for years now. Paul said this data does seem to have given them the information they need. Michael said even if the state is receiving the rebates, they could give the ACOs a balance of this in their rates. Michael said we will have to figure out contractually how all these things will work.

Michael mentioned different risks in regard to this. He said we are going to be putting in a building block request in regard to this. This is an issue between the Medicaid agency and the federal government in regard to that piece. Michael said they will be asking for the 8%. He said in many instances we may not be getting the 23.1%. Michael said we will try to provide the ACOs with as much information as we can.

The 340B was mentioned and whether the ACOs could get a better savings by purchasing all of their pharmaceuticals at a 340B rate. Would this prevent the others from doing rebates? Michael said the Department of Health would have to look at this to make sure they are held harmless.

Michael said out-of-network payment limits were on the list to be discussed. The Medicaid fee schedule is all that could be charged for these out-of-network issues. Michael said this would be an additional item for cost issues being reduced. Michael said the Department of Health may have to look at what things will have to be changed to control some of this. This would be the same for an emergency. This was in regard to Medical Homes. The criteria for a Medical Home need to be defined. Michael said this would include the whole range of providers.

Paul mentioned that we have to be careful on where the care is being provided. A lot of different comments were made in regard to this and all the factors that need to be considered. The difference between managed care and ACOs was mentioned. It was mentioned that the state does not want to limit providers to one or the other. The state's concern is that an entity be willing to take the risk and manage them.

NCQA standards in regard to an ACO were mentioned and also looking at some of the pieces in regard to a Medical Home. In answer to a question, Michael said that before Medicaid can pay an out-of-state provider, the provider has to become a Utah Medicaid provider. Michael said he feels this has already been addressed in some of our past discussions. Michael said he feels we can work through these specific issues.

Michael thanked everyone for their participation. Next week there will be a client incentives discussion, but there have been a couple of requests to move that. Do people want to keep it for April 13th or move it to April 27th? Michael said the current issue for April 13th will be moved to April 27th. The April 27th meeting will now be client focus on client incentives for healthy behaviors, and the April 13th meeting will be client focus on cost sharing. Everyone agreed and these two meetings will be switched as discussed.

The meeting adjourned at 10:20 a.m.